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27 February 2010

Pricing up pharmacy

EXCLUSIVE: Details of cost of service inquiry revealed

See page 4

PLUS

when nicorette® patch meets nicorette® gum something remarkable happens

nicorette® combi™ patch + gum – a new conception in smoking cessation

51% more effective at helping smokers quit compared with 15mg patch alone at 12 weeks ($p<0.05$)[1]*

patch + gum prescribed as one

*34.2% quit on Combination NRT vs. 22.7% quit on 15mg patch at 12 weeks ($p<0.05$)

Nicorette combi patch + gum Product Information

Presentation: Invisi 15mg 16 hour patch and Icy white 2mg gum. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation in smokers who smoke 10 or more cigarettes per day, experience breakthrough cravings, or who have previously failed on monotherapy. **Dosage: Adults (over 18 years):** Patients should stop smoking during treatment. The patch should be applied to the skin, hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. The gum should be chewed slowly for about 30 minutes when there is an urge to smoke. The patch and gum should be used together for the first 12 weeks. For the next 6-12 weeks, only the gum should be used. The gum should then be weaned for up to 9 months from the start of treatment. A maximum of 15 pieces of gum per day should be used. Those who use NRT beyond 9 months should consult a healthcare professional. **Adolescents (12 to 18 years):** As per adults except the patch and gum should be used together for 8 weeks only. For the next 4 weeks, only the gum should be used. Usage should be weaned over this period and discontinued after 12 weeks from start of treatment. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. *Patch only:* generalised dermatological disorders. Erythema may occur. If severe or persistent, discontinue treatment. *Gum only:* Denture wearers, GI disease. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Not recommended. **Side effects:** Headache, GI discomfort, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. *Patch only:* itching. *Gum only:* hiccups, sore mouth or throat, jaw-muscle ache. See SPC for further details. **RRP (ex vat):** Pack containing 7 Invisi 15mg Patches and 70 Icy white 2mg gum: (£22.56), **Legal category:** GSL. **PL number:** 15513/0359 **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **Date of preparation:** November 2009

Reference: 1. Kornitzer M et al. Prev Med 1995; 24: 41–47.

Date of preparation: January 2010

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Editor's comment

'NOW THE RPSGB IS ON RECORD AS SAYING THERE IS NO CLINICAL EVIDENCE FOR HOMEOPATHY, WHAT IF A PATIENT COMPLAINS ABOUT A PHARMACY'S DECISION TO SELL THE REMEDIES?'

Keith Ridge's quite candid admission about how positively pharmacy responded to the swine flu pandemic will be warmly greeted by pharmacists (p6).

Speaking at the Sigma Conference in China last week, England's chief pharmacist recognised the sector's central role in managing the pandemic and his statement that this had "not gone unnoticed" by government ministers must bode well for what is fast becoming a crucial year for community pharmacy.

His call for pharmacists to continue their commitment to the NHS by helping it find an eye-watering £15-20 billion of savings over the next three years can be taken as good or bad news, depending on where you see the savings coming.

But one area that will now face more scrutiny than Chelsea footballers is the NHS's spending on homeopathy, following a scathing report by MPs this week (p5).

The Commons science and technology committee's examination of the evidence behind government policies on homeopathy could not be clearer in demanding that the government stop spending scarce NHS resources on homeopathy.

The 47-page document covers everything from the evidence – or lack of – for homeopathy, the MHRA's licensing procedures and, perhaps most interestingly for us, the role of pharmacies.

As a profession we really don't come out well. The committee highlights our claim to be the scientists on the high street, which begs the question, how do we square this with selling something that our professional body has said has no scientific or clinical evidence to support its use?

Of course it's down to individual businesses to decide what they do and don't sell. But here's an interesting scenario: now the RPSGB is on record as saying that there is no clinical evidence for homeopathy, what happens if a patient complains to the Society about a pharmacy's decision to sell the remedies?

The government intends to respond to the committee's findings by the end of April and it'll be interesting to see if it continues to defend the spending of NHS resources on homeopathy.

The debate, which has clearly caught the public's interest, is not yet over and pharmacy's role will continue to come under the spotlight. In a week that has seen the government singing the sector's praises, the last thing we need is another damning Which? or Daily Mail investigation.

Gary Paragpuri, Editor

News

Features

Cost of service questionnaire 'comprehensive' say experts

Pharmacists must take time to complete the forms properly to give a true picture of costs

Zoe Smeaton/Jennifer Richardson
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Pharmacists taking part in the sector's cost of service inquiry have received their questionnaires and told C+D they had been asked to return them to accountancy firm PricewaterhouseCoopers (PwC) in two weeks.

The questionnaire, which has been seen by C+D, asks pharmacists about their working hours, accounts and the proportion of their time spent on different aspects of the business.

But experts have warned that pharmacists must take time to complete the forms properly or risk jeopardising the future viability of their businesses.

The inquiry questionnaires, which have been circulated by PwC, ask pharmacists to specify how they divide their time between NHS-related activities such as dispensing and clinical governance, non-NHS aspects of the business and areas such as staff management.

Pharmacists are also asked to detail pay levels, the services they offer and how many patients use them, as well as how often they review SOPs.

Staff pay and working hours are covered by the survey, and pharmacists must outline future plans to invest in the business together with the value of assets such as IT equipment, shelving and motor vehicles.

Pharmacists have until March 12 to return their cost of inquiry questionnaires to PricewaterhouseCoopers

Experts reviewing the survey for C+D said it looked comprehensive. Andy Harwood of Pharmacy Partners said: "I think it looks very well put together and covers most of the angles we would expect."

Numark and the NPA both said they expected the inquiry would reveal that there had been funding deficiencies.

But industry leaders stressed that to achieve this contractors needed to invest time in completing the survey correctly.

Hiten Patel, managing director at Pharma Plus, said it was vital that pharmacists struggling with the questionnaire sought help, possibly from their LPCs. He added that contractors needed to take time to ensure the true costs were captured, not forgetting, for example, any hours spent working on the business from home.

Umesh Modi, a specialist pharmacy financial adviser, cautioned that an accountant completing the form would probably charge around £500, yet he understood contractors were being paid only £100 to take part in the survey.

Cost of service questionnaire

THE TOPICS
Services offered, employees, owner income and work, premises and assets, future plans, and financial information

TIMELINE
March 12: ideal deadline for submission of questionnaires
Mid-April: PwC expected to complete work on the inquiry
October: PSNC plans ready

PSNC has 'strong' team for cost inquiry

PSNC has established a "strong" team to work on the cost of service inquiry, head of finance Mike Dent reassured the Sigma Conference in Shanghai last week.

A steering committee for the cost of service inquiry included contractors from PSNC's negotiating team as well as independent experts, such as a professor of entrepreneurship and an economist, Mr Dent said.

"We have a good, strong panel of experts who are sitting there with us to make the case for cost and the returns needed," he added.

The work of accountancy firm PricewaterhouseCoopers is expected to be completed by mid-April, Mr Dent said. PSNC hoped to have "something" ready by October, though he did not elaborate on how comprehensive this would be.

PSNC had been lobbying hard to suggest to policy makers that investment in community pharmacy would deliver "clever" savings for the NHS, Mr Dent added, although he cautioned that "times were tough". **ZS/JR**

C+D Awards deadline extended

The deadline for entries to the C+D Awards 2010 has been extended by one week.

Entrants now have until 5pm Friday March 5 to submit their entries and join the best community pharmacy has to offer, vying in 14 categories for a coveted C+D Award.

Those shortlisted will be invited to a gala awards ceremony on Wednesday June 9 at the Grosvenor House Hotel in the heart of London's glamorous Mayfair. Previous hosts for the awards have included top comic talents Michael McIntyre and Paul Thorne.

For your last chance to enter and raise one of this year's trophies, go to www.chemistanddruggist.co.uk/awards. The site contains details of the categories, everything you need to enter, handy hints and tips on your entry and profiles of last year's winners. **CC**

C+D AWARDS 2010

NHS should not pay for homeopathy, MPs say

C+D Homeopathy Survey results back up committee conclusions

Chris Chapman
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Homeopathy should not be funded on the NHS and the MHRA should stop licensing homeopathic products, a group of cross-party MPs has said.

Their conclusions were backed by the communuity pharmacy sector as almost three quarters of respondents to a C+D poll said the remedies should not be funded by the NHS.

Homeopathy reduced patient choice, threatened safety, and risked damaging patient trust, the House of Commons Science and Technology Committee said in a report released this week.

The report criticised the government's position on the remedies as "confused", calling for scientific officers to meet and agree on positions. The committee said it believed evidence conclusively demonstrated that homeopathy was no more effective than placebo, and that further research on its efficacy could not be justified.

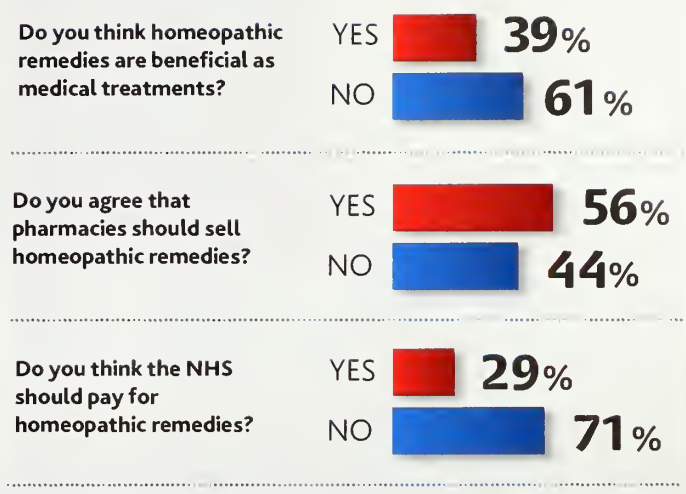
Patient choice was "meaningless" if patients were not fully informed that homeopathy was a placebo, the committee argued. And as any placebo effects are diminished if patients are informed, provision of homeopathy on the NHS "diminishes, not increases, informed patient choice", the report said.

The MPs said the MHRA should also remove all references to homeopathic provings from its guidance, other than to make clear they were not evidence of efficacy.

Meanwhile in a C+D survey of more than 100 pharmacists, 71 per cent said they did not think the NHS should pay for homeopathic remedies and 61 per cent said they did not believe homeopathy was beneficial to patients.

However, 56 per cent of respondents believed pharmacies should be able to sell homeopathic remedies.

The C+D Homeopathy Survey results



Source: C+D Homeopathy Survey, February 2010, 119 respondents

Committee brands RPSGB stance on homeopathy 'unsatisfactory'

The RPSGB has been criticised for its suggestion that it would be better for patients to buy homeopathic remedies from pharmacists, who could offer advice on the matter.

The Commons Science and Technology Committee said in its report this week that as the Society agreed there was no scientific or clinical evidence for homeopathy, "the only advice pharmacists could give is the products are placebos".

The MPs said pharmacists must ensure patients with symptoms who may require further investigation were not led to believe homeopathy could offer any more than this effect.

However the MPs added that it would be "pointless to seek to remove homeopathic remedies from sale in pharmacies" as the products were easily available over the internet. Instead, labelling of the remedies should make it clear that there was no evidence that they worked beyond the placebo effect.

The committee also expressed concern over the time the Society had taken to investigate and reach conclusions where pharmacists were accused of breaking guidance on selling homeopathic remedies.

It cited an investigation into some pharmacies said to be claiming homeopathic remedies could treat malaria in place of conventional anti-malarials. This began in 2006 but has still not been concluded.

"We recommend that the government enquires into whether the RPSGB, and from the 2010 handover, the General Pharmaceutical Council, is doing an adequate job in respect of the time taken to pursue complaints," the report added.

The committee's concerns were refuted by the Society, which said it was "surprised and disappointed" at the comments. "In all fitness to practise cases our aim is to satisfy ourselves that all aspects of the case have been thoroughly looked into... as in any legal process this can and does take time," a spokesperson said. **CC**

In brief

Prescription warning

PCTs have been warned not to manipulate prescription periods to reduce pharmacy payments, PSNC has said. The committee was currently negotiating a "deterrent" with the DH, head of finance Mike Dent told the Sigma Conference in Shanghai.
www.chemistanddruggist.co.uk

Working with GPs

Details of joint guidance from the RPSGB and the RCGP to help pharmacists and GPs work together are expected to be released in early March, the Society has confirmed.

Consultation extension

The MHRA has given stakeholders extra time, until March 29, to respond to the organisation's consultation on strengthening the medicines supply chain.
http://tinyurl.com/yff9ale

Remote dispensing

A remote dispensing system involving a two-way video conference with a pharmacist is expected to announce its entry into the UK market shortly. The MedCentre system was welcomed by trade minister Lord Davies at the Global Investment Conference this week.

Gaviscon OFT objection

The Office of Fair Trading is to decide whether Reckitt Benckiser broke the law by allegedly seeking to restrict competition by withdrawing and delisting NHS packs of Gaviscon Original Liquid. The manufacturer has stated it believes it competed fairly and "within the letter and spirit of the law" and would respond to the allegation.

C+D winner

Congratulations to Stephen Montgomery of Belfast, who wins an iPod Shuffle for participating in this month's C+D homeopathy survey.

The clinical link between asthma and rhinitis
See p20

Read more on Sigma's China conference
www.chemistanddruggist.co.uk

COPD consultation

DH officials have opened a consultation on its long awaited strategy for tackling COPD. Key aims include identifying the disease earlier, and pharmacists were said to be able to help patients with asthma manage their condition.
http://tinyurl.com/COPDconsult

Antivirals ease flu

Antivirals can prevent the development of confirmed influenza, according to a Cochrane Library meta-analysis. Both zanamivir and oseltamivir were found to reduce the average duration of symptoms by less than one day if started within 48 hours of symptom onset.
http://tinyurl.com/viralprevent

No statins/diabetes link

A Lancet meta-analysis has failed to find a statistically significant link between statin treatment and diabetes. The analysis found a slightly increased risk of development of diabetes in statin users, but the risk was low compared with the reduction in coronary events.
http://tinyurl.com/yzxlau5

Pregnancy guidance

A consultation on draft guidance for pharmacists on weight management in pregnancy and after childbirth has been launched by Nice. It closes on March 18.
www.nice.org.uk

Pharmacy film festival

Nineteen short films made by pharmacists have been screened at a festival held in Long Beach, California. They featured everything from action movies such as Kung-Pharm-Fu to music video Consultation Lockdown, which walked away with the best picture award.
http://tinyurl.com/2010FilmFest

Sector should lead NHS out of crisis, CPO says

Role in swine flu pandemic showed spirit, Sigma conference hears

Jennifer Richardson
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Community pharmacy must harness the "spirit" of its swine flu response to deliver unprecedented change and secure the sector a leading role in solving the NHS cash crisis, England's chief pharmaceutical officer has said.

Speaking at the Sigma Conference in China last week, Keith Ridge told delegates pharmacy had played "a central role in an effective response to the swine flu pandemic" and had "pulled all the stops out".

He said: "This has not gone unnoticed, not only by the public, but also by ministers and officials at the Department of Health."

The sector must now capture that spirit to play a "leading role" in delivering NHS savings of £15-20 billion over the next three years, Dr Ridge said. "If this isn't the time for a mixture of clinical and innovative business skills, then I don't know what is. And who has those in primary care? Community pharmacy," he added.

Pharmacy's central role in responding to the swine flu pandemic "had not gone unnoticed" by ministers, England's chief pharmacist Keith Ridge (centre) told delegates at the Sigma Conference

Dr Ridge said community pharmacy could lead the way in delivering the changes in primary care necessary to meet NHS cash challenges.

Examples of solutions deliverable by the sector included reducing preventable adverse drug events and improving medicines adherence, he explained.

"You now need to capture the spirit of the pandemic over the last few months to help deliver a scale and pace of reform so far unseen," Dr Ridge said.

'Wake up' to PCT power, GP warns

Pharmacists must "wake up" to increasing PCT power, an Oxfordshire GP has warned.

Lisa Silver told the Sigma Conference in Shanghai last week not to "underestimate" PCTs' control over pharmacy funding and services, particularly with the advent of pharmaceutical needs assessments (PNAs) and global sum devolution from April.

"[Pharmacists] have got to wake up to the fact that you need to start negotiating with your PCTs," Dr Silver warned.

All pharmacists should know the director of commissioning at their PCT, and read their overarching joint strategic needs assessments as well as PNAs, she advised.

LPCs would need to be "much more powerful", she added. "If your LPC gets themselves recognised as a body to be negotiated with, it will look good for you."

Party manifestos 'difficult to distinguish'

The major political parties are proving difficult for community pharmacy to distinguish between as all have an "overwhelmingly positive" approach to the sector, PSNC has said.

The comments came as the Liberal Democrats launched their health manifesto, pledging to support the drive for more in-pharmacy primary care services.

PSNC head of NHS services Alastair Buxton said the plans could refer to increasing point of care testing and screening. "This is just the type of service we've been lobbying for," he said.

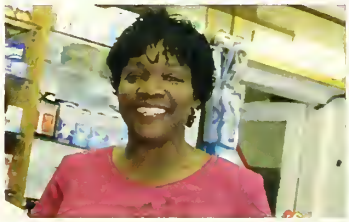
But he was sceptical that there was much in the way of policy differences on pharmacy between the main political parties, saying the committee hoped to tease out some new information about party plans in the next few weeks. **GMA**

Bio-Oil® is a specialist skincare oil that contains a combination of natural oils and vitamins, together with the breakthrough ingredient PurCellin Oil™. It was developed in 1987 and is today the number one selling scar and stretch mark product in 12 countries. It is available at pharmacies at the recommended price of £8.95. For comprehensive product information please visit bio-oil.com. Bio-Oil® is a product of Union Swiss, successfully treating skin since 1954.

Dispensary talk

What is the most important skill pharmacy graduates are missing?

"Pharmacy graduates need to hone their communication skills. I find that sometimes graduates don't handle situations with customers and staff as well as they should and they can be too terse."
Gurminder Sall, Jeeves Chemist, Iver Heath, Buckinghamshire



"Working in a pharmacy is not just about having clinical skills. I would like to see pharmacy graduates developing basic managerial skills to help them manage their staff and their pharmacies more effectively."
Aina Osunkunle, K and A Pharmacy, Gateshead

Web verdict

Basic numeracy 9%

Ability to communicate 39%

Clinical knowledge 12%

Confidence 31%

Nothing 8%

Armchair view: It's bad news for students as hardly any pharmacists think they are up to scratch on all fronts after their degrees.
Next week's question:
Are you confident the cost of service inquiry wil deliver fairer funding for pharmacy? Vote at **www.chemistanddruggist.co.uk**

Reprimands may follow Boxing Day confusion

PCTs consider action against some pharmacies closed on Boxing Day

Gavin Atkin
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PCTs are considering taking action against pharmacies that failed to open on Boxing Day 2009 after a late change in the date of the bank holiday wrong-footed many contractors.

The trusts could refer owners to disciplinary committees or take action using fitness to practice powers, according to guidance issued by NHS Primary Care Commissioning (NHS PCC).

The document did advise, though, that if the failure to open had been an isolated incident and patient safety had not been compromised, action may not be needed.

Pharmacies came under pressure to change their opening hour plans after the official bank holiday was switched from Saturday December 26 to Monday December 28 by royal proclamation in November.

Some pharmacies refused to switch dates and open on the Saturday, saying it would have been unreasonable to change staff hours at such short notice. But in doing this some contractors will have broken their terms of service.

PSNC head of regulation Steve Lutener said the committee had stressed to NHS PCC that PCTs should be accommodating where pharmacies could present information demonstrating very low demand for services on December 26 in previous years.

Mr Lutener added that he hoped there would be more clarity for 2010 with improved arrangements for confirming opening hours and applying for changes around bank holidays.

Pharmacists facing PCT disciplinary action or experiencing problems regarding opening plans for this year's holiday periods should contact PSNC for advice.

Closing time?

In the confusion over Boxing Day opening hours, pharmacies took different approaches to the issue. Thirty eight Asda pharmacies did not open on Saturday December 26 after the bank holiday was moved. John Evans, superintendent pharmacist , said legal advice had suggested it would be unreasonable to change staff's plans so late in the day.

But in Gateshead, Fairman's Chemists complied with the PCT's decision to require every pharmacy in the area to open on December 26. "We only have one pharmacy in Gateshead, and I went in and did it myself," managing director Chris Forster told C+D. "I'm going to write to the Palace to ask them to make their proclamation for next year as early as possible," he added. **GMA**

A pioneering outpatient service bringing together community pharmacy and secondary care has been officially opened by England's chief pharmaceutical officer Keith Ridge (pictured centre). The Lloydspharmacy outpatient scheme, in partnership with the Royal Liverpool University Hospital, provides outpatient dispensing for haematology, gastroenterology, pain and renal clinic patients. Outpatients using the service are able to collect prescriptions at the pharmacy, which is located within the hospital. Pharmacist Russell Genge told C+D working in the pharmacy involved lots of clinical work, including talking to consultants and learning about the different clinics. Training for the role had included shadowing hospital pharmacists and working on patient case studies, he said. KO

Gunshots leave staff 'traumatised'

A Lloydspharmacy staff member has been left "extremely traumatised" after shots were fired in an attempted robbery at the multiple's Bolnore Village branch in Sussex.

A man entered the pharmacy at 4pm on Monday, February 15 and fired two shots from a handgun towards the ceiling, Sussex police said. The robber demanded money, threatened a heavily pregnant pharmacy assistant and then fled empty handed.

No one was hurt in the incident and the premises were not damaged, but the police said staff had been left shocked, describing the assistant as "extremely traumatised".

Lloydspharmacy said it was assisting with police enquiries. It also pledged to step up security.

Two men, both aged 19, were arrested in connection with the attempted robbery, and have been bailed until May. **CC**

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GX-003-09 Date of preparation December 2009

Children's cough syrups

McNeil Products will introduce two new children's cough syrups on March 1. Benylin Children's Apple Flavour Cough Syrup will replace Benylin Children's Tickly Coughs and CalCough Infant Syrup will replace CalCough Tickly. Both new products are clear, colourless syrups with an apple flavour and glycerol as the active ingredient. Both products are indicated for dry, tickly coughs in children aged from three month to five years.

Price: £2.97/125ml
McNeil Products
Tel: 01628 822222

Pharma Nord dates

The Pharma Nord Symposia for 2010 will be held from March 22 to 25 in hotels in Manchester, Leeds, Bristol and Leicester. Topics will include wellbeing, immunity and sexual health. Endurance athlete Noel Hanna, nutritionist Gareth Zeal and pharmacist Dennis Gore will discuss Pharma Nord products. The events are free for pharmacists.

Pharma Nord UK
Tel: 0800 591 756

Pharmaton Capsules relaunch puts the emphasis on vitality

Boehringer Ingelheim will relaunch Pharmaton Capsules with a new look and name in March. The vitamin supplement will be renamed Pharmaton Vitality Capsules and its orange packaging will include new branding.

The packs will also feature two energised silhouette figures to illustrate that the product is designed to help relieve tiredness by prolonging energy levels.

The formulation will remain unchanged: G115 ginseng extract with a blend of vitamins A, B, C and D, calcium and folic acid.

The capsules have a licensed medicine status and clinical trials show that they can help combat that worn out, run down feeling and have an active therapeutic benefit.

The manufacturers recommend taking one capsule per day with food. If a customer starts to feel better after four weeks' treatment, they are advised to continue taking the capsules for up to 12 weeks at a time. After 12 weeks they should talk to a doctor if they wish to continue taking the capsules.

Prices: £8.99/30, £15.99/60, £21.99/100
Pip codes: see C+D Monthly Pricelist or www.cddata.co.uk
Boehringer Ingelheim
Tel: 01344 424600

Slow-release glucosamine joins JointCare range

Seven Seas intends to revitalise the joint care category with the addition of sustained release glucosamine to its JointCare range in April.

Seven Seas JointCare Opti-Release is formulated to slowly release glucosamine into the gut to provide a continuous release of glucosamine over a 12-hour period.

The manufacturer recommends taking up to two tablets each day to provide the recommended level of glucosamine for optimum joint health comfort.

Seven Seas says this product has been developed using patented technology designed to release glucosamine over a sustained period to provide consumers with steady and continuous nutritional support for their joints throughout the day.

The tablets contain no artificial colours, preservatives, starch or sugar and are gluten- and yeast-free.

Price and Pip code: £11.99/30, 353-5887
Seven Seas Health Care
Tel: 01482 375234

Check out what's on TV this week and take part in the Retail Talk poll

www.chemistanddruggist.co.uk/prodnews

New-look Epaderm ointment

Mölnlycke Health Care has a new look for its Epaderm Ointment, which is suitable for very dry or cracked skin conditions including eczema and psoriasis.

The new packaging is designed to help pharmacists and pharmacy assistants to distinguish between Epaderm Ointment and Epaderm Cream, which is suitable for people with less severe dry skin conditions.

To help reduce possible confusion between the two, Epaderm Ointment packs have been updated to directly reference the product as an ointment.

Containing yellow soft paraffin, emulsifying wax and liquid paraffin, Epaderm Ointment is a greasy emollient that provides a film barrier over the skin. It is formulated to help soothe the skin, reduce the itch and prevent moisture loss.

Packaged in three tub sizes, the ointment is suitable for use at night when long-term moisturisation is needed.

Price: £6.67/125g, £11.32/500g and £20.84/1kg
Mölnlycke Health Care
Tel: 0800 7311 876
www.skincare-world.com

GSK to remove zinc from Poligrip

GlaxoSmithKline has announced plans to remove zinc from its Poligrip denture adhesives due to concerns that long-term excessive use of zinc-containing denture adhesive is associated with potential health risks.

The company has halted production of existing Poligrip Ultra and Poligrip Total Care products, which both currently contain zinc.

GSK says the zinc in these adhesives may lead to high levels of zinc in the body if used excessively for several years. High levels of zinc can be associated with numbness, tingling or weakness in the arms and legs, walking and balance difficulties and blood problems such as anaemia.

GSK told C+D both products are safe if used as directed and neither needs to be recalled or removed.

Customers who have been using either product for several years in greater amounts than directed on the pack, such as using it more than once a day, or who have concerns about their health, should stop using the product, switch to a zinc-free alternative and talk to their GP.

GlaxoSmithKline Consumer Healthcare; tel: 0205 047 2500

Sex worth talking about

The Government's new **Sex. Worth Talking About** campaign seeks to join up activity and improve conversations amongst all those who engage with young people. It looks to establish a culture of open, mature, and well informed discussion about safer sex and better relationships; normalising conversations about sexual health, relationships, contraceptive choices and protection against STIs.

The campaign aims to help with the implementation of both the Sexual Health and HIV Strategy and the Teenage Pregnancy Strategy, through facilitating easier, everyday discussions about contraception and chlamydia testing between peers, partners and healthcare professionals. Pharmacists have an important role to play in encouraging these conversations and helping young people to approach them.

Evelyne Beech

Pharmacist, Gloucestershire

Pharmacies are on every high street, so they're ideal places for spreading the messages far and wide about the importance of chlamydia testing, and of the contraceptive choices available to young people.

In my pharmacy, we provide free chlamydia testing kits to all under 25s. We point out that they are being offered to their entire peer group, so they don't feel singled out. We support this with our point of sale information leaflets.

I always emphasise to young people how easy the test is. We can act as a one-stop-shop, because we also offer treatment over the counter free of charge to them and their partner/s.

When I'm approached by a young person looking for contraception, I mention that there are a number of other options that might be suitable for them. I'm not pushy, but I like to make them aware that their choice doesn't end at the pill and condom. I always join up the conversations too, so a patient looking for condoms or Emergency Hormonal Contraception is offered a chlamydia test, and someone presenting or collecting a pill prescription is made aware of the other longer acting contraceptive choices and of chlamydia screening.

Case Study

Heather, aged 23

Six years ago, I found out I had chlamydia. I didn't have any symptoms, but my boyfriend at the time started experiencing discharge, so we both went to the local sexual health clinic and tested positive for chlamydia. I was also advised to inform previous partners.

I now get tested for chlamydia every six months. They offer kits at my local pharmacy where I get my contraception from, so I do it there. It's free, simple and painless. The pharmacists are always very helpful. I even received my results by text message last time!

National **Chlamydia Screening** Programme

department for children, schools and families

DH Department of Health

For more information about the campaign, plus a range of downloadable materials and best practice examples, visit **www.nhs.uk/sexualhealthprofessional**

Xrayser

Where is it all heading next for pharmacy?

> IF MY GRANNY WAS ADMITTED TO A SURREY HOSPITAL, THAT WRIST BAND MIGHT BE A PRICE TAG

When I graduated with my pharmacy degree all those years ago, I thought I knew it all. Then I started my pre-reg year, and quickly realised that I didn't. Of course, once I finished my pre-reg and registered with the RPSGB, I truly thought I knew it all. And then real life began.

There are some things that can't be taught, such as 'life skills'. Employers' concerns about the numeracy and literacy of graduates can be addressed, but you can't learn from a text book how to deal with patients who may be upset, frightened or irrational. You can't teach a student how to recognise a potential shoplifter or pacify the recipient of a dispensing error. That comes with pharmacy experience, along with the grey hairs and the ulcer.

What graduates entering community pharmacy need to learn is finance and commissioning. As we await the cost of service inquiry results, and rumble along the bottom of recession, an essential skill is that business mind to identify new services and – more importantly – get paid for them.

Now I wouldn't sell my granny to make a profit, but if she was admitted to a Surrey hospital that wrist band might be a price tag, because while pharmacists are being lambasted for profiteering by selling essential drugs abroad and causing suffering by the shortage this creates, it turns out the Royal Surrey County Hospital (RSCH) has been flogging the contents of its pharmacy department to a wholesaler to the tune of £4.6 million. This isn't 'an insignificant amount' of wholesaler dealing by anyone's measure, but then they did make £300,000 profit, which would pay for quite a few of those giblet operation thingies hospitals seem keen on. The DH has described such action for short-term financial gain as unacceptable, but what about long-term financial gain?

For example, my area has seen a sudden increase in prescribing for a particular branded generic. This is estimated to save the average PCT just as much and the increase in its prescribing has led to it being in short supply. Is such manipulation of the drug market really so different to what RSCH has done?

So can we learn from the secondary care entrepreneurial zeal? Faced with rising expenses – and now many of us have to face the primary care tsunami that is the polyclinic – we need more than ever to develop areas such as vascular screening or sexual health services. But we can't just sit back and wait, we need to be co-ordinated and approach the PCT as consortia of pharmacy providers. That's still a new concept for many pharmacists, and we could learn a lot from the doctors – but only those in primary care.

GPs are experts in promoting themselves as providers, and obtaining a fee for every action they take – maybe these are the skills that pharmacy students really need to develop.

Mike Hewitson

A tale of two pharmacies – which are you?

Imagine two identical pharmacies in two different PCTs. The first, which we will call Dave's Pharmacy, has a very pro-pharmacy PCT; the second, Eddie's Pharmacy, exists in a wasteland where monies negotiated at national level for pharmacy are diverted to fill his PCT's financial black hole. But how can some PCTs be allowed to effectively opt out of a national funding deal to balance their own books?

Since the inception of the current contract in England in 2005, pharmacies have been 'allowed' to make profit (£500 million between 9,775 pharmacies in 2005 vs £500m between 10,872 pharmacies in 2009) on the purchasing of medicines. Profits beyond this £500m cap are removed via category M. Unfortunately some PCTs have pushed the use of branded generics or off patent brands, which limit a contractor's ability to earn a fair slice of the margin pie, as they have in Eddie's case. This produces savings in the PCT prescribing budget, at the expense of pharmacy funding.

So our two identical contractors, Dave with no branded-generic use and Eddie with high use, who face equal costs and provide the same service, are left with completely lop-sided funding, potentially to the tune of thousands of pounds. If the Department of Health was to get generic substitution right, the problem could be eradicated by allowing pharmacies to substitute the generic for the branded generic.

Eddie has become worried that his PCT is planning to divert monies intended to pay for essential services by encouraging longer prescription cycles. He has lost faith in his PCT after the branded generics issue and is starting to feel the pinch from the new 100-hour pharmacy down the road. Meanwhile, Dave is in the enviable position that the devolution of the global sum will probably mean few changes to his working life. It remains to be seen what safeguards have been put in place to stop PCTs eyeing their portion of the global sum to subsidise their other functions. It is unfortunate for Eddie that those organisations already seeking to use branded generics are the most likely to try to usurp the fair apportionment of the global sum. Again, the gap between Eddie and Dave's funding grows ever wider.

The contract has brought great variation between the commissioning of enhanced services from area to area; this is well documented, including a special investigation last year in C+D. Fortunately for Dave's pharmacy, he has been able to invest time and effort in developing his business model to take advantage of these new sources of income. But for Eddie's pharmacy, the future remains a world away.

Mike Hewitson, owner, Beaminster Pharmacy, Dorset

> HOW CAN SOME PCTS EFFECTIVELY OPT OUT OF A NATIONAL FUNDING DEAL TO BALANCE THEIR OWN BOOKS?

Features

Update

Your weekly CPD revision guide | **Module 1515**

The management of COPD

Respiratory Health Month

The last article in this series covers the treatment of COPD. See the previous three Updates on respiratory disease at www.chemistanddruggist.co.uk/update

60-second summary

This article, which can be used as part of your CPD, explains how COPD progresses and latest recommendations for drug treatment.

What do I need to know about drugs for COPD?

The latest data show no increased risk of death associated with long-acting bronchodilators and anticholinergics in COPD, but safety continues to be monitored. Further research is also needed into the increased risk of pneumonia with inhaled corticosteroids.

What can I do for patients?

The focus has moved to meeting patients' emotional, rather than just physical symptoms. This includes end-of-life care and training to improve communication between patients and professionals.

This article (Module 1515) can help in the following CPD competencies: G1a, G1c, G1d, C1a, C1b, C1d, C3e.
See http://tinyurl.com/68ox7b

Your role in supporting COPD patients

Doreen Cochrane MRPharmS

Despite progress in diagnosis and treatment through national and local initiatives, chronic obstructive pulmonary disease (COPD) still causes significant morbidity and mortality. The disease leads to high levels of economic, social, physical and emotional distress for patients and carers.

COPD is not just a disease of the lung. Possibly as a result of systemic inflammation, it is not unusual to find COPD associated with cardiovascular disease, skeletal muscle dysfunction (contributing to exercise limitations), nutritional abnormalities and weight loss. Patients may be asymptomatic in the early stages of the disease but progress to experience a variety of symptoms. Nice guidelines published in 2004 recommend a patient-centred approach to assessment and treatment to reflect individual differences, and the physical and emotional effects on the patient. A further guideline is expected in June.

In general, the goals of COPD management are to:

- prevent disease progression
- relieve symptoms
- improve exercise tolerance
- improve health status
- prevent and treat complications
- reduce mortality.

Approach to MURs

The patient-centred approach to management outlined by Nice is tailored to interventions for patients who are asymptomatic, symptomatic, experiencing disability, having frequent exacerbations, or have symptoms associated with end-stage disease.

Asymptomatic Patients will benefit from an annual influenza vaccine and five-yearly pneumococcal vaccination. A healthy diet containing adequate vitamins and minerals is important at this and later stages. Weight loss benefits patients who are overweight or obese (BMI over 25). In later stages of the illness, underweight patients (BMI less than 20) and those with cachexia have increased mortality and benefit from referral to a dietician.

All patients who smoke should be offered support to stop. Smoking cessation usually diminishes the symptoms of chronic bronchitis and eliminates the accelerated decline in lung function seen in susceptible patients who continue to smoke. Methods for assisting patients include nicotine replacement therapy and nicotine receptor blockade (varenicline) with individual or group support. Success rates vary.

Symptomatic Patients benefit from the addition of pharmacological treatment. The Nice guideline recommends a gradual increase in intensity of medication depending on disease severity and individual response to treatment. Many patients have difficulty using their inhalers and review of inhaler technique is important.

Disabled by COPD Patients who have difficulty doing usual daily activities should be referred for pulmonary rehabilitation unless their co-morbidities prevent this. Pulmonary rehabilitation (PR) is a multidisciplinary programme of exercise and education that aims to reduce breathlessness on exertion, increase exercise capacity, improve patients' ability to function independently and manage their symptoms. The service is increasingly available in the community.

Many patients suffer from anxiety and depression because of the unpredictable nature of their illness. They may benefit from participation in an Expert Patient Programme, as this will help to reduce feelings of isolation and improve self-management skills. Anxiety and depression may also be treated with antidepressants, counselling or group psychotherapy.

Patients having frequent exacerbations Self-management plans should be discussed with patients who suffer exacerbations and should include details of:

- how to recognise an exacerbation – either increased sputum, discoloured sputum or feeling feverish or unable to complete normal activities
- triggers associated with worsening of COPD include weather changes, bacterial and viral infections and a smoky environment
- when to use 'rescue' courses of antibiotics and oral steroids
- when to contact an appropriate healthcare professional.

Patients who are known to have COPD and who present with increased dyspnoea or an alteration of their normal cough and sputum may be experiencing an exacerbation. Such patients must be evaluated for ischaemic heart disease, congestive heart failure, pneumonia, pneumothorax, pulmonary embolism and lung cancer.

End-stage disease or 'failing lung' Patients need to be referred to specialist services. Until recently these have been hospital-based but are now sometimes provided by consultants in community settings. Secondary care treatment allows further assessment of complications including cor pulmonale (large ventricle enlargement resulting from disease of the lungs or pulmonary blood vessels), sleep apnoea, need for long-term oxygen treatment (LTOT), management of severe

exacerbations, treatment of co-morbidities and possible surgical intervention.

The need for LTOT should be assessed in all patients with severe airflow obstruction, that is an FEV_1 less than 30 per cent of predicted, and those with signs of hypoxemia, such as cyanosis. Assessment may also be considered in patients with moderate airflow obstruction. Supplemental oxygen (at least 15 hours a day), reduces mortality rates in patients with advanced COPD. Much of the medical care at the end of life for patients with COPD is disease-directed and becomes increasingly ineffective as COPD progresses.

Communication skills Several reports have highlighted that patients with COPD often do not understand their condition. Failure in communication between healthcare professionals and patients may also lead to patients not being aware of their choices. This is particularly important near the end of life when interventions are often aimed at managing physical symptoms, whereas patients feel that they need more holistic approaches that address their emotional and spiritual needs, not only their physical problems. The collaboration between the British Thoracic Society and Primary Care Respiratory Society aimed at Improving and Integrating Respiratory Services in the NHS (IMPRESS) has recently developed a package of communication training materials aimed at improving care for patients titled Living and Dying with COPD.

Many community pharmacists already provide services for patients with palliative care needs being cared for in their homes or in hospices. The end-of-life needs of patients with COPD have been poorly recognised.

Pharmacological management Inhaled medications can improve COPD symptoms, reduce the frequency and severity of exacerbations, improve lung function, exercise capacity and quality of life, but none reduce mortality. The overall approach should be to assess an individual's response to a trial of a drug, the drug's side effects, patient preference for inhaler devices, and cost.

For breathlessness and exercise limitation, patients should start by using a short-acting bronchodilator, as needed. If the patient is still symptomatic, the options are to try combined therapy with a short-acting $beta_2$-agonist (SABA) and the short-acting anti-cholinergic, ipratropium. Long-acting bronchodilators, either a long-acting $beta_2$-agonist (LABA) or the long-acting anti-cholinergic tiotropium are recommended for patients who remain symptomatic on short-acting drugs or have two or more exacerbations each year requiring treatment with oral antibiotics or oral corticosteroids.

Nice recommends that patients who have an FEV_1 less than or equal to 50 per cent predicted and who remain symptomatic on a LABA should have an inhaled corticosteroid (ICS) added, usually in combination with a LABA.

Short-acting bronchodilators Salbutamol and terbutaline are the most widely used SABAs in COPD. Their onset of action is slower than in patients with asthma. Patients may experience dose-related side effects resulting from systemic absorption, including tremor, cramp, nervousness and tachycardia. To reduce systemic absorption, the dose should, where possible, be administered from a metered dose inhaler (MDI) with a volume spacer.

MRC dyspnoea scale grade

Grade	Degree of breathlessness related to the grade
1	Not troubled by breathlessness except on strenuous exercise.
2	Short of breath when hurrying or walking up a slight hill.
3	Walks slower than contemporaries on ground level because of breathlessness, or has to stop for breath when walking at own pace.
4	Stops for breath after walking about 100 metres or after a few minutes on level ground.
5	Too breathless to leave the house or breathless when dressing or undressing.

Ipratropium is the only short-acting anticholinergic licensed for treatment of COPD. It reduces bronchoconstriction, with onset in about one hour, and provides sustained bronchodilation for up to eight hours. Side effects include dry mouth, cough and blurred vision.

Long-acting bronchodilators LABAs reduce exacerbations in patients with COPD including those severe enough to require hospitalisation. There has been concern that LABAs increase the risk of death from respiratory causes among patients with asthma or COPD. However, data from the Toward a Revolution in COPD Health (TORCH) trial and also from a recent analysis of a large patient database reveal no evidence for increased mortality associated with $beta_2$-agonist therapy. Nevertheless the MHRA continues to monitor the safety of these drugs in COPD.

The long-acting anticholinergic (tiotropium) may be superior to LABAs in reducing total exacerbations due to COPD. The most common side effect with tiotropium is dry mouth, with nausea and headache less common; constipation and urinary retention occur rarely.

Recent data has suggested that anticholinergic therapy in patients with COPD may increase the risk of death from any cause, cardiovascular death, and cardiovascular events; however, no increases in adverse cardiovascular events or death were seen in the Understanding Potential Long-term Impacts of Function with Tiotropium (UPLIFT) trial and further analyses are needed to shed light on any increased risk.

Corticosteroids For patients with a FEV_1 less than or equal to 50 per cent and who have had frequent exacerbations in the previous year, an ICS should be considered, usually in combination with a LABA. The dry powder combinations of formoterol 6 or 12mcg/budesonide 200 or 400mcg Turbohaler or salmeterol 50mcg/fluticasone 500mcg accuhaler are licensed to be given twice daily and provide a sustained improvement in lung function and symptoms with a reduction in exacerbations including hospitalisation.

Side effects of inhaled corticosteroids include oral thrush and dysphonia, osteoporosis, skin thinning, purpura and cataracts. An increased risk for the development of pneumonia, which was seen in the two arms of the TORCH trial that used ICS therapy, has been supported by analysis of a large patient database. Further research is needed, particularly in relation to the profile of adverse events and benefits, in relation to the different doses of ICS.

Potential side effects of oral corticosteroids include hypertension, weight gain, mental changes, infections, cataracts and glaucoma, skin thinning, pituitary-adrenal suppression and osteoporosis.

Methylxanthines Theophylline could be considered if the patient remains symptomatic on ICS/LABA therapy. Oral theophyllines are effective bronchodilators and may increase respiratory drive, relieve skeletal muscle fatigue, and have anti-inflammatory and inotropic properties. However, because of theophylline's high risk side effect profile, drug interactions and narrow therapeutic index, inhaled therapy is preferred. The interaction between theophylline and the macrolide antibiotic erythromycin and quinolones, which are often used to treat exacerbations, requires intervention.

Mucolytics Patients with distressing viscous sputum may benefit from mucolytic agents, which are available in either capsules (carbocisteine or mecysteine) or syrup (carbocisteine). Erdosteine is a mucolytic with antioxidant properties and is licensed for the treatment of exacerbations with productive cough.

Conclusion

Most pharmacists are already providing MURs and some may be providing MURs specifically for COPD, as a local enhanced service commissioned by their PCT. Reviewing how patients use their medicines allows the possibility to improve the patient's quality of life while minimising potential risks.

There is a need for PCTs to provide leadership that integrates community pharmacy into the care pathway for this challenging condition.

Further resources are in the full version of this Update at www.chemistanddruggist.co.uk/update.

Doreen Cochrane MRPharmS trained as an independent pharmacist prescriber in respiratory conditions.

Update subscribers: download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.

NEXT WEEK
How OTC tamsulosin fits into the management of benign prostatic hyperplasia (BPH)

The management of COPD

Reflect

How would a patient recognise an exacerbation of their COPD? Which short-acting anticholinergic is licensed for treatment of COPD? At what stage might an inhaled corticosteroid be added to COPD treatment?

Plan

This article discusses how the management of COPD is tailored for patients who are asymptomatic, symptomatic, experiencing disability, having frequent exacerbations, or having symptoms associated with end-stage disease. It also includes information about the medications used in treatment and MUR considerations.

Act

- Read the MUR tips for COPD on the C+D website at http://tinyurl.com/MUR-COPD. Think about the advice you could give to your COPD patients.
- Update your knowledge of smoking cessation from the Patient UK website at http://tinyurl.com/smoke-cess, and revise the NRT products in C+D's Guide to OTC Medicines and Diagnostics. Find out how you could provide this service if you do not already do so.
- Find out more about pulmonary rehabilitation from the Patient UK website at http://tinyurl.com/ye3dr34.
- Find out more about the Expert Patient Programme from the Patient UK website at http://tinyurl.com/yblwh4b and www.expertpatients.co.uk.

Evaluate

Are you now confident in your knowledge of COPD and its management? Could you give advice to patients about the medications prescribed and the non-pharmacological management that may help them live with their condition?

5 minute test
What have you learned?

Test yourself in three easy steps:

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Practical Approach | Test yourself in this everyday pharmacy scenario

Treating tennis elbow

At the Update Pharmacy pharmacist David Spencer has been called to see a man who has asked at the medicines counter for painkillers for a painful arm. David takes him to the consultation area and asks him to explain his problem further.

"It's me arm, mate. Just here," the man says, grasping his right elbow.

"How long have you had the pain?" David asks.

"It's been coming on for a couple of months. But it's got so bad now that it's agony to do my job."

"And what's that?"

"Painter and decorator. It hurts just to grip a brush, and using a roller on a ceiling is an absolute killer."

"Would you mind telling me how old you are?"

"Forty seven."

"Have you seen your doctor about this?"

"No, mate, haven't got the time. All I want is some good painkillers so I can get on with my job."

"All right," David says. "Can I have a look at your arm?"

The man agrees and David gently feels around the muscles at the top of his forearm and the bony prominences around his elbow, both of which make the man wince. David then asks him to raise his hand as if he were stopping traffic, at which he again winces.

"Well," says David, "I think I know what your problem is. It's not serious, but just the same you may not like what I have to tell you."

Questions

1. What is the man likely to be suffering from, what is its cause and what is its usual course?

2. Can the condition be treated with OTC medication?

3. Why might the man not like what David has to tell him?

4. Might the man get more effective treatment from his GP than David can advise?

Answers

1. Tennis elbow (lateral humeral epicondylitis), an injury typically affecting the dominant arm and resulting from repetitive wrist strain. It is common, affecting men and women equally with incidence peaking at age 35 to 55. It is common in occupations that involve repetitive turning or lifting at the wrist, such as gardening, keyboard use, plumbing, decorating and bricklaying. Episodes typically last six months to two years and usually resolve within 12 months. Acute pain typically lasts six to 12 weeks.

2. OTC paracetamol, co-codamol, or oral or topical NSAIDs provide adequate pain relief for most patients. RICE (rest, elevation, compression, ice) may be helpful in the initial stages of treatment.

3. The man should rest his arm, ie not work, until the pain subsides – usually around 10 to 14 days. He should then perform gentle stretching exercises (which can be found on various websites dealing with tennis elbow) to improve wrist flexion, extension and rotation.

4. Injection of corticosteroids with local anaesthetic can produce short-term pain relief, but is no more effective in the long term than no treatment. And steroid injections should not be used as long-term treatment as they can hinder tissue healing and lead to tissue degeneration.

This article can help with these CPD competencies: **G1a, G1c, G1d, G2o, C1a, C1f.**
See http://tinyurl.com/68ox7b

Do you have an idea for a Practical Approach scenario or would you like to write one? Email us at: **haveyoursay@chemistanddruggist.co.uk**

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practical approach**

Have you experienced something similar? How did you resolve it? Email C+D at haveyoursay@chemistanddruggist.co.uk

ETHICAL DILEMMA

This series aims to help you make the right decisions when confronted by an ethical dilemma. In the last issue of every month we present a scenario likely to arise in a community pharmacy and ask a practising pharmacist and/or a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **haveyoursay@chemistanddruggist.co.uk**

Disclosing information

The dilemma

Mr X has type 2 diabetes and takes various oral medications plus insulin. He uses the pharmacy's prescription collection service, leaves his repeat request slip at the pharmacy and phones to order his repeat medication. Most months a representative collects his dispensed medicines. Mr X is due to attend a hospital appointment today. His sister (who often collects his prescription) calls in to the pharmacy and asks for a copy of his repeat prescription so that her brother can avoid having to take all his medicines into hospital. Should you provide the photocopy to someone who often collects this patient's medicines? You have no phone number for the patient and understand that he is leaving shortly to attend the appointment.

This situation happened in our pharmacy. We gave the photocopy to the patient's sister as she often collected his prescription and we believed we were acting in the patient's best interests.

It turned out that no hospital appointment existed and that the sister needed a photocopy of his repeat prescription to prove he had diabetes and was using insulin. The sister had recently been to another pharmacy that was running a promotion in which a free blood glucose meter was being offered to all insulin patients. She thought that he could benefit from a new machine and promptly obtained one using the photocopied repeat list.

Mr X was not happy his sister acted without his consent, nor was his wife as her sister-in-law often interfered in matters regarding her husband's health. They both believed we had broken their trust in failing to restrict access to their personal information. They believed we had neglected our responsibilities under the Data Protection Act.

We, of course, apologised. We explained that we were told an elaborate and fictitious story in order to obtain the photocopy and that, had this situation been genuine, then we believed we were acting in the patient's best interests. The patient acknowledged this sentiment but was adamant that we should not have acted without his prior written authorisation. We did try to explain that, as he was content for his sister to collect his medicines on a monthly basis, to sign the exemption declaration on the prescription and to check the items prescribed, we believed this implied his consent to his sister's access to his pharmacy-related information.

The patient is still a regular client and has since concluded that his sister was mainly to blame for creating the problem, but he advised that we review our procedures. So now all similar requests for potentially sensitive information must be dealt with by the pharmacy manager or pharmacist on duty. Wherever possible, the patient is contacted directly before supplying any such information.

Lee Doherty MRPharmS is pharmacist manager, Manor Pharmacy, Letchworth, and Graham Phillips MRPharmS is superintendent pharmacist, Manor Pharmacy Group, Herts.

Where does the law stand?

The Code of Ethics and the NHS Code of Practice on Confidentiality both place an obligation on pharmacists to keep patient information confidential. Disclosure of confidential information is permitted only in limited circumstances – most obviously if the patient consents.

Contrary to the patient's assertion, there is no reason why his consent should be in writing (which would usually be impractical), although any oral consent should be recorded on the pharmacy's PMR. The patient should understand what information will be released, in what circumstances and what the consequences are likely to be. Only the minimum information necessary for the purpose should be released.

In this case, the pharmacist would no doubt seek to justify his actions by stating the patient had consented to details of his prescription being shared with his sister as she often collected his medication. As the sister was already aware of the information in the prescription, supply of a photocopy did not disclose any additional confidential information. However, apologising to the patient and reviewing the pharmacy's procedures was the appropriate response.

Pharmacists should consider obtaining a phone number for all patients who are using a repeat prescription service (or a delivery service), because issues such as the one described are not rare but could be resolved by calling the patient.

Noel Wardle is a solicitor at Charles Russell LLP, specialists in pharmacy law.

This article can help in the following CPD competencies: **G1a, G1d, G2a, G2m, G2k, G5f, G5k. See http://tinyurl.com/68ox7b**

More dilemmas are online at www.chemistanddruggist.co.uk/ethicaldilemma

PLEA

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement **www.wingfieldworks.co.uk/plea/index.html**

Next month's Ethical Dilemma
Can you sell a POM pack of EHC?

We need more Ethical Dilemmas. If you have an interesting scenario that you can share with your fellow pharmacists, get in touch via haveyoursay@chemistanddruggist.co.uk

To increase patient satisfaction your advice is indispensable.

"Children with generalised atopic eczema typically require about 250g per week or more of an emollient."
Latest NICE Guidelines

Parents look to you for advice. So recommend the E45 Cream pump pack because it makes it easier to apply the correct dosage.
E45 is an emollient that is specially formulated for the treatment of dry skin and eczema. Each press of the pump dispenses ~ 4 grams of cream.
So, three pumps, three times a day is designed to add up to to 250g weekly.
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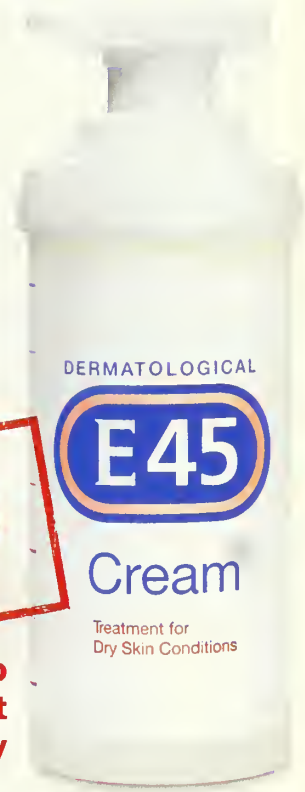

PUMP 3x3 A DAY

to help keep infant eczema away

DERMATOLOGICAL
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HEALTHY SKIN FEELS GREAT

Prescribing Information E45 Cream. E45 Cream is a white smooth emollient cream containing white soft paraffin 14.5% w/w, light liquid paraffin 12.6% w/w and hypoallergenic anhydrous lanolin 1.0% w/w. **Uses:** For the symptomatic relief of dry skin conditions where the use of an emollient is indicated, such as flaking, chapped skin, ichthyosis, traumatic dermatitis, sunburn, the dry stage of eczema and certain dry cases of psoriasis. **Dosage and administration:** Adults, children and elderly: Apply to the affected part two or three times daily. **Contraindications:** E45 Cream should not be used by patients who are sensitive to any of the ingredients. **Undesirable effects:** Occasionally, hypersensitivity reactions, otherwise adverse effects are unlikely, but should they occur, may take the form of an allergic rash. Should this occur, use of the product should be discontinued. **Package quantities:** 50g tube, 125g tub, 350g tub, 500g pump pack. **Basic NHS cost:** 50g £1.40, 125g £2.55, 350g £4.46, 500g £5.39. **Legal category:** GSL.

Product licence number: PL 0327/5904. **Product licence holder:** Crookes Healthcare Ltd, Nottingham NG2 3AA.

Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to the Medical Information Unit, Reckitt Benckiser, Hull (0500 455 456).

Date of preparation: September 2009

CPD Reflect • Plan • Act • Evaluate

What this article means for your practice

- There is growing evidence that asthma patients with upper airway allergy symptoms benefit from treatments aimed at nasal symptoms.
- Pharmacists can consider contributing to patient care in two ways, first by asking questions designed to identify asthma patients who also have rhinitis, and second by offering these patients a trial of an OTC steroid spray aimed at reducing nasal symptoms.

The clinical link between rhinitis and asthma

New studies have highlighted a clinical connection between asthma and rhinitis. **Gavin Atkin** looks at the future of asthma treatments, and the advice pharmacists should give patients

The link between rhinitis and asthma is well recognised. They're both allergic reactions mediated to a greater or lesser extent by the IgE immunoglobulin, and it's known that many rhinitis sufferers have some degree of asthma and that around 80 per cent of patients with asthma also have some rhinitis symptoms.

But the ways in which these two conditions are regarded and treated by medical professionals are far apart. Asthma, a destroyer of quality of life and a potential killer, is naturally taken very seriously; its diagnosis and management is a national priority for primary care, and there are rigid guidelines describing treatment.

By comparison, however irritating and disruptive they may be, the symptoms of rhinitis are seen as trivial and are often ignored. Surveys suggest as many as two thirds of asthma patients report that they have never discussed rhinitis symptoms with their GPs.

But what if evidence emerged to show patient outcomes could be improved by treating these closely-associated conditions as if they contributed to each other?

The case for the rhinitis and asthma clinical link

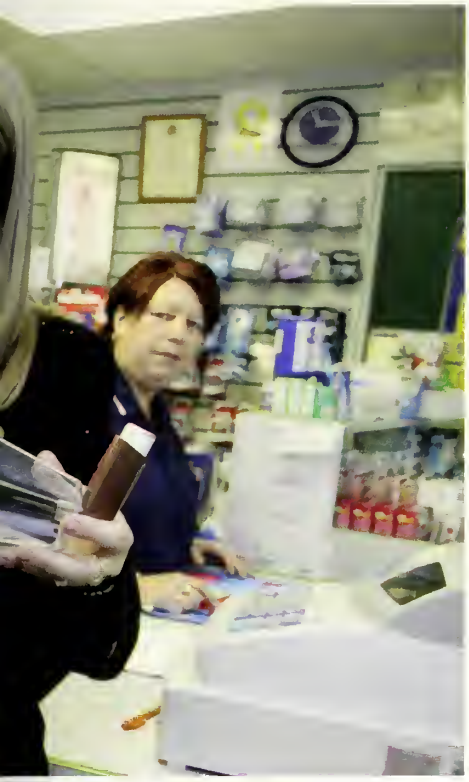
Increasingly, that evidence is already here. The connection between rhinitis and asthma was first noted by the physician Charles Blackley, who published his seminal book Experimental Researches on the Causes and Nature of Catarrhus Aestivus (Hay Fever or Hay Asthma) in 1873. Its title may have been loaded with meaning, but somehow in the following decades both medical science and patients often neglected the link. Drug firms have focused on developing one group of treatments for lower airway allergy symptoms and another for upper airways symptoms, and patients, medical professionals and policy makers have not made a priority of rhinitis.

Nevertheless the link is clear, as David Price, professor of primary care respiratory medicine at the University of Aberdeen, explains. "A study we published in the Primary Care Respiratory Journal in December found that if you take a population of 100 asthmatics, about one third will say they have no rhinitis to speak of.

"Another third have mild rhinitis symptoms; but don't have much bother from it. It doesn't seem much, but this group are twice as likely to have poor asthma control. But the final third have symptoms they say impact on their quality of life at least some or all of the time, and this group is four times more likely to have poor control of their asthma."

Could it be that rhinitis is just a marker that identifies patients with the most marked allergic inflammation, or can researchers give us hard evidence that controlling rhinitis symptoms can help in the battle to control asthma?

Even as recently as the 1990s, the word rhinitis hardly appeared in asthma guidelines, but this



Around 80 per cent of patients with asthma have some rhinitis symptoms. Could single OTC treatments for one help the other condition?

changed in 2001 with the Allergic Rhinitis and its impact on Asthma (ARIA) document published in collaboration with the World Health Organization. The ARIA document argued health professionals should look for rhinitis in patients with asthma and for asthma in patients with rhinitis, and should where possible seek a common treatment.

The evidence for some aspects of the ARIA recommendations may have been a little flimsy at the time, but the arguments in favour of treating allergy symptoms in both ends of the airway have been borne out by a jigsaw of evidence from subsequent studies.

Anti-leukotriene antagonists: the missing part of the jigsaw?

Professor Price and his colleagues have often been at the forefront of efforts to complete the puzzle.

Observational work presented at the American Thoracic Society meeting last year showed that in people who had asthma with rhinitis, adding a long-acting beta antagonist to an existing inhaled steroid treatment was less effective in the presence of rhinitis than in its absence. The same study found a trend to better outcomes in patients taking an anti-leukotriene antagonist, which treats the upper and lower airways at the same time.

To this we should add the analysis of the COMPACT trial, led by professor Price. COMPACT was a study in adults whose asthma symptoms were continuing despite inhaled corticosteroids. The headline finding was that adding montelukast (which treats both upper and lower airways) to patients' budesonide improved their morning PEF as much as doubling the steroid dose. This added weight to the argument for treating both upper and lower airways, but there was more to come – for when his group re-examined the COMPACT data they found that the results for trial subjects with rhinitis showed that adding anti-leukotrienes was actually more effective than doubling the steroid dose.

Yet more data his group presented at the European Academy of Allergy and Immunology meeting last year showed that using nasal steroid treatment in addition to inhaled steroid therapy gives better results than inhaled steroid alone.

Professor Price argues that a clear hierarchy of outcomes is emerging: "The best thing of all is to treat both the upper and lower airways; the next best thing is treating the lower airway with more anti-inflammatory, and the least good thing is simply to give reliever therapy to the lower airway." He adds that the evidence is also showing that both ends of the airway should be treated properly – it's not enough to treat either the upper or lower airway alone.

There now seems little doubt that the recommended treatment approaches in asthma will change to include rhinitis more explicitly – though this will take time. But even in the absence of new guidelines, professor Price argues community pharmacists have a golden opportunity to help asthma patients during MURs and in general counselling.

What pharmacists can do

Perhaps the most important part of this is identifying asthma patients who also have rhinitis – they tend not to talk about the issue in the doctor's surgery, but a well timed enquiry from a pharmacist could tease out the information. In this situation patients may be recommended to see their GP or try an OTC treatment with the aim of improving their nasal symptoms.

"Many patients with asthma should be recommended to try an OTC nasal steroid. The courses have to be quite short – but if the patient has nasal symptoms it may be reasonable to give a trial of something that will improve them and at the same time to tell them to look out for an improvement in asthma.

"If they do get an improvement in their asthma symptoms, they really should talk to their doctor," says professor Price.

Would professor Price recommend any particular type of steroid nasal spray? "The only thing I'd say is that in children you wouldn't want to use a beclomethasone spray on top of inhaled beclomethasone for the lungs. If you put the two together you get a slightly increased risk of potential side effects because it's biovailable.

"But I would have no hesitation in recommending any of the modern sprays: the oral bioavailability of fluticasone propionate, fluticasone furoate or mometasone furoate are very low."

Why not try antihistamines? They're likely to be unsuitable, says professor Price. "They may be good for milder rhinitis, but are less useful for people with the more severe symptoms likely in patients with asthma."

Clinical summary

What's the connection between rhinitis and asthma?

The fact that rhinitis and asthma are closely linked and that managing rhinitis can contribute to improving asthma symptoms is well known, but rarely acted upon.

What's changing in this area?

The evidence that treating rhinitis can also improve asthma control has grown rapidly, and it now seems inevitable that future asthma guidelines will have much more to say on the issue.

What's the pharmacist's contribution in this area?

As treating rhinitis becomes a mainstream part of asthma management, patients will need to understand changes in their medications.

A key role for pharmacy is in identifying asthma patients with rhinitis – this group frequently does not mention rhinitis symptoms to their doctor. Also, it may be rewarding to ask asthma patients whether they have rhinitis symptoms and, if so, a trial of an OTC steroid spray can be suggested. If their asthma improves together with their rhinitis symptoms, the pharmacist may advise the patient to discuss the issue with their GP.

Further reading

- Allergic Rhinitis and its Impact on Asthma (ARIA) (2001). Pocket guide at http://tinyurl.com/rhinitis-asthma
- Clatworthy, J, Price, D, Ryan, D et al (2009). The value of self-report assessment of adherence, rhinitis and smoking in relation to asthma control. Primary Care Respiratory Journal 18(4): 300-5.

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V for victory

She's the only pharmacist to win a C+D Award two years in a row. Valerie Sillito tells **Max Gosney** what it takes to be a record breaker

Rumour has it that the C+D Awards organisers have created a Valerie Sillito signature stamp to save time on engraving trophies. She won in 2008, she triumphed again in 2009 and she's on the hunt for a historic hat-trick or even quadruple this year.

"Winning Community Pharmacist of the Year the first year was a huge surprise," the Aberdeen-based pharmacist says. "I really didn't expect it and it was a special moment." Ms Sillito plans to compete in Team of the Year and Clinical Service categories in 2010. However, right now it is as C+D Prescriber of the Year 2009 that she reigns.

"I'm no better than the next pharmacist," she stresses. "I'm just well known among GPs and the local health board." Those links have not happened by chance. Ms Sillito brims with enthusiasm for her work, and her assurance in approaching GPs is refreshing.

She set up her award-winning supplementary prescribing clinic targeting COPD sufferers after discovering doctors were missing out on QOF points in the area. "We need to move away from feeling subservient to GPs," she says. "It might have been that way in the 80s, but pharmacy has moved on. We should be able to ring them up and discuss things as partners."

Her golden tip to any aspiring pharmacist is simple. "If you're a branch manager who has moved to a new area, the first thing you need to do is pick up the phone to the surgery and introduce yourself. It's important to get a bit of chit chat going." Once you're familiar to the local doctor, doors will open, she adds. "If they know your name then why wouldn't they use you?"

The GPs in Aberdeen are not just familiar with Ms Sillito's name, though. She walks half an hour to the surgery after her clinics to hand deliver patient notes. It's indicative of her 101 per cent approach. Ms Sillito's weekly diary balances day job with supplementary prescribing clinics, a project with a local university and chairing the local Boots branch to name but a few. The desire is in the blood, she says. "I'm passionate about what I do. I think patients are lovely."

The feeling appears to be mutual. Ms Sillito's COPD clinic has expanded to cover three surgeries and a homeless centre. She has also gone on to set up a hypertension clinic. Typically she'll see around eight COPD sufferers from the consultation room of Boots in Aberdeen's Bon Accord shopping centre. The reviews take a maximum of 30 minutes, during which time Ms Sillito will measure lung function with a spirometer. The appointments are co-ordinated by her local surgery.

> "Winning the first year was a huge surprise ... it was a special moment"

Ms Sillito has enlisted the help of fellow pharmacists to keep on top of the expanding clinics. One colleague has been trained to do hypertension and another substance misuse. Yet she is perplexed by others who have qualified as independent prescribers but never put their skills into practice. "I think a lot of pharmacists are frightened. It's a problem we have, pharmacists not taking that final step and running a clinic."

There are other teething troubles under the powers introduced in 2006. Ms Sillito bemoans the lack of IT link up with GPs and limits on prescribing to her listed patients. However, the work is highly rewarding, she stresses. "I might look like Florence Nightingale but I'm not. For me it's just a way of expanding my pharmacy knowledge."

The moment that catapulted her to award success

One moment that changed my life forever. "If I didn't do that then I wouldn't be here," explains Valerie Sillito of the career-defining decision she took 20 years ago.

Ms Sillito, a mum of two young children at the time, went back to university to do a postgraduate clinical pharmacy course. She has not looked back since. "My message is, it's never too late. You hear people say, 'I'm too old.' Well of course not."

Ms Sillito's studies laid the foundation for her pursuit of supplementary and independent prescribing qualifications. "If somebody offers you education then take it," she says. "I had two young children when Boots offered me the course and I didn't have my mother-in-law down the road to look after them, but I coped."

Name
Valerie Sillito (pictured above left)

Pharmacy
Boots, Bon Accord Centre, Aberdeen

Award won
C+D Pharmacist Prescriber of the Year 2009

Award entry
Overcame logistical problems to develop COPD prescribing clinic and expand into hypertension

Valerie's entry tips

Don't write it as a 'look at how wonderful I am' essay
"You need to give a frank account of what you have done and why it matters."

Write it yourself
"You won't get that heartfelt style if somebody else writes it for you."

Stock up on supplementary evidence
"When I judged the Awards last year I couldn't believe the lack of extra evidence submitted by pharmacists. It's a missed opportunity. I included lots of letters from patients and colleagues when I entered. I phoned the senior pharmacist at our health board and asked him to write a testimonial, which he was happy to do. This evidence gives the judges a real insight into how what you do impacts on real lives."

Look at the criteria
"It's very clear from each category what the judges want you to demonstrate, so base your entry on answering these points."

Entry for the **2010 C+D Pharmacist Prescriber of the Year Award** category, PLUS from GSK sponsored by PLUS from GlaxoSmithKline, is now open. Go to **www.chemistanddruggist.co.uk/awards** for full entry details, hints and tips, to download an entry form or enter online.

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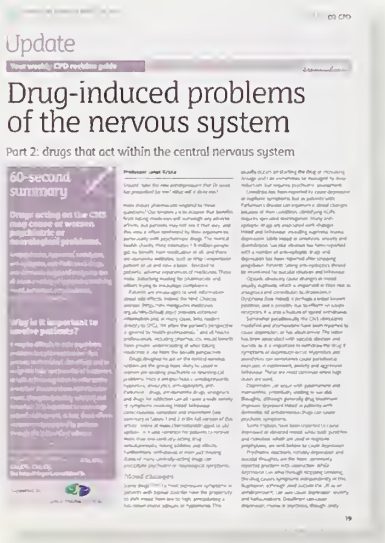
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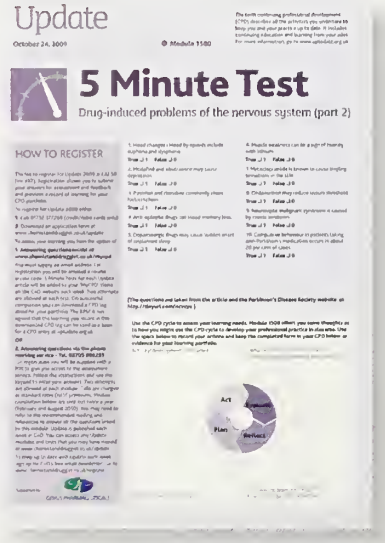
Drug-induced problems of the nervous system

Part 2: drugs that act within the central nervous system

60-second summary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5 Minute Test

Drug-induced problems of the nervous system (part 2)

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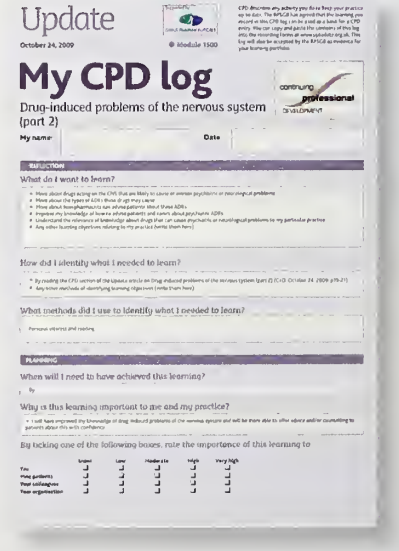
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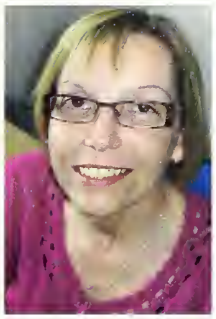

The Co-operative Pharmacy HR operations business partner Tracy Murray (pictured) responds:

A Essentially, an employment contract specifies a rate of pay, and in accepting the contract you accept the rate of pay offered. The exceptions to this are: if your rate of pay is below the national minimum wage; or if men and women in your branch are being paid different rates of pay for doing the same job. If the latter is the case you would have a claim under the Equal Pay Act.

I would suggest that in the first instance you talk to your manager about your concerns regarding your salary. You may not have been given the correct information by your colleague, or may not be aware of the full circumstances surrounding your pay. A conversation with your manager should clarify this. If you are not happy with the outcome you can raise a formal grievance. However, you should be aware that an employer is able to offer different pay scales based on, for example, length of service, location and contract type.

If your branch is covered by a collective agreement (negotiated between an employer and a recognised trade union) then you should consult your union to see if your grade/salary is covered under the agreement.

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Manager malaise

We all have to answer to someone at work, but what happens if they are treating you unfairly? **Zoe Smeaton** looks at what you should do

As admin piles up, patients' demands intensify, and breaks from the pressure become few and far between, it's easy to see why working in a pharmacy can be stressful. A good manager should offer you support in such situations, so what happens if your boss seems to be making life even harder for no apparent reason?

The first thing you should do is acknowledge the problem. Diane Lester, charity manager at Pharmacist Support, says people often think their situation is normal and all work is like this. John Murphy, director of the Pharmacists' Defence Association (PDA), agrees: "Pharmacists tend to be very compliant, and many won't stand up for their rights."

But if your boss is making you feel as if you're not doing your job properly, then there could be a problem. Mr Murphy says unrealistic targets from managers are a "key problem" and he has seen some managers dumping work onto pharmacists rather than delegating effectively. "There are also domineering managers who won't listen, and those who don't seem to value your contribution," he adds.

If you think your boss fits into any of these categories then Ms Lester and Mr Murphy agree that you should take action as soon as possible. If you don't, Mr Murphy says over time your self-esteem could suffer, which will hinder your performance at work and so is bad news for your career. It could also lead to more stress and harm your health.

As Ms Lester warns: "Pharmacists work in a very controlled environment under a lot of pressure, so the additional stress of not getting on with someone could be too much to bear." And on a practical level, if you leave things until the manager has decided to punish you, Mr Murphy says raising concerns can look as if you are just trying to get back at them.

Is your boss being unreasonable? Address the problem early, is the advice

Taking action is unlikely to be easy, but there are some things that can help you. The first step may be talking to your boss, and this could be easier than you think.

Yvonne Tuckley, Numark's training manager, says in many cases bosses can be unaware of the stress unrealistic targets are causing. She suggests approaching the topic proactively. "Try and use evidence to back up your thinking. Also give some thought to possible solutions." Mr Murphy says asking for feedback is vital, and he advises asking managers for specific examples if they are claiming that you have underperformed. "If they are trying to demean you professionally and are challenged on this, nine times out of 10 they can't do it," he says.

If this doesn't work then you may like to talk to someone else. Ms Lester says for some pharmacists calling the charity's Listening Friends helpline, where they can speak to another pharmacist confidentially, can be helpful. You should also see what your company has to offer – find out their policy on bullying and harassment and follow the official procedures. Many larger employers will have confidential employee support services, or you could approach your HR department.

If you decide to raise a grievance against your employer, there are also options. As Mr Murphy says: "People have employment rights, they can take out a grievance against their managers – harassment is seen as a very serious misdemeanor in employment tribunals." Both the PDA and Pharmacist Support can offer advice on such matters.

Whether or not you decide to take legal action, you might be tempted to leave your job. Given the variety of employers in the pharmacy market, and the option to work as a locum, taking yourself out of the situation could be a good move.

It's worth looking at potential employers to ensure they have the right measures in place before you start. Large companies are likely to have structures in place, but even small pharmacies might outsource their HR, for example, meaning you could approach someone who wouldn't also be your boss.

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Postscript...

Online with C+D

Talking points

"I am mindful we will always have our entrenched critics along with those who are drowning in apathy, disenfranchisement and torpor but we also have to be mindful that mud-slinging and confrontation are an old concept that we wish to move away from."
English national board vice-chair Sultan Dajani responds to concerns over the RPSGB board elections. Posted on C+D online.

To post a comment, simply register at www.chemistanddruggist.co.uk/register

The top stories last week

1. CPD reviews: the results are in
2. Boots to urge YouTube to remove leaked training video
3. Update 1513: Is it asthma or COPD?
4. Multiples blast contract funding as Lloyds looks to make job cuts
5. Update 1514: Treatment options for managing asthma

Really easy competition

All right, this is getting a bit silly now. A few weeks back Postscript put up a competition to give away a copy of Martindale 33 – a huge, weighty tome jam-packed with useful information. All we wanted from you was a picture of your pharmacy.

How many entries did we get? Somewhere between diddly and squat. Not a single entry. Currently, the book is just gathering dust on Postscript's desk, looking lonely and unloved. So this is it, your last – and best – chance to get a copy of the book before it is unceremoniously thrown in the bin.

The first community pharmacist to send Postscript the correct answer to the following question, which is about as difficult as an evening telly competition, gets the prize.

Which of these is a common drug dispensed in the UK?

a) Bendroflumethiazide
b) Banoffee pie
c) Belgium

Taxing, isn't it? Email Postscript with your answer: postscript@chemistanddruggist.co.uk

C+D Reader of the week

Meet Duns pharmacist George Romanes, and find out which film with a cliffhanger ending is his favourite

If you could have a superpower for the day, what would it be? Pharmacy's easy after these questions! It would be to have some kind of time power, so I could have a 27- or 30-hour day.

What do you have for breakfast? Muesli, tea and toast. I'm quite regular about that.

What's the first thing you do when you get home? I help my wife set the table for tea. We try and sit down for dinner every night.

What's the biggest challenge for pharmacy in the next year? In Scotland, it's getting to grips with the chronic medication service and the online record system. It's a new way of working.

What service would you most like to see? We've got a minor ailments service, so I guess it would be a 'keep well' check, to check a person's blood pressure, blood glucose etc. We can help people in their 40s before they have problems.

What's your favourite movie? Oh, that's tough. It's hard just to pick one. I guess for entertainment value it's the original Italian Job, with Michael Caine. I still like the remake, though – I have the DVD at home.

What should we ask the next interviewee? What's the most annoying thing in your daily routine?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk or call 0207 921 8086

Web Hunter

Very late last Friday evening my Postscript counterpart, The Victorian Pharmacist, called me.

"Um, I've got a confession," he says. "I've broken the website."

"@$%@£! hell, it's 9pm on Friday night. What are you doing working on the site?"

"Well I was just trying to..."

I could repeat the conversation verbatim, but nonetheless www.chemistanddruggist.co.uk was down until 10.30am the following morning, when I had a brainwave about how to fix it.

Then, on Wednesday, a DNS error (or a 'don't know, sorry' error) took the site down for an hour and a half, during which I could do nothing but twiddle my fingers.

So you get an idea of the sort of week I've had. But why is this relevant? Well, reports vary widely, but IT outages cost the UK economy an estimated £7-14 billion a year. And that's a lot of money.

So now weigh up the cost savings of replacing a qualified frontline pharmacist with a remote supervision robot that could fail. Or imagine the impact of your PMR system going down. Or having to write all of your labels out by hand.

OK, sure, people go off sick too. But it strikes me that the more we replace the human factor with piles upon piles of IT gadgetry, the more risk we have of destroying customer service and, at worst, public health.

Don't get me wrong – I work on the web and love techy stuff. But the thing that makes the web interesting is the people who use it. Take for example @pillmanuk on Twitter, who loves telling me what he thinks our website should look like and then apologises for making the remarks. Keep the remarks coming @pillmanuk – you make the web interesting. Without people, IT is just a DNS error waiting to happen.

Niall Hunt is C+D's digital content editor; email him at niall.hunt@ubm.com

C+D's week in tweets

@CandDChris: Pregnant women do not need to 'eat for two', says Nice draft guidance. It's still a pretty good excuse to have that extra cupcake.

@CandDJennifer: Sigma conf: bartering in the Terracotta army shop – doubt anyone will get a life size replica back on the plane, even if they've a spare £2,000.

@CandDMax: GP-led health centre, polysystem or polyclinic? What's the difference and which one would you snog, marry or avoid?

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*Nielsen volume data 52 w/e 26th December 2009